

STANDARD CERTIFICATE OF DEATH

State File No. 42454

10773

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST Louis. Mo		c. LENGTH OF STAY (In this place) 1 hrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST Louis. Mo		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5545 Wells				d. STREET ADDRESS (If rural, give location) 5545 Wells 0			
3. NAME OF DECEASED (Type or Print) a. (First) Mianie		b. (Middle) C		c. (Last) Kessels		4. DATE OF DEATH (Month) (Day) (Year) 12-15-1950	
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Aug 30 - 1877	
9. AGE (In years last birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Missouri. Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Joseph Gimbel		13b. MOTHER'S MAIDEN NAME Kathryn Kottmeier		14. NAME OF HUSBAND OR WIFE Herman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME H. N. Kessels		ADDRESS 5545 Wells	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>arterio-sclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Diabetes mellitus</u>				8 yrs			
DUE TO (c) <u>Senility</u>				8 yrs			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Slip</u>			
22. I hereby certify that I attended the deceased from Jan, 1946, to 12-16, 1950, that I last saw the deceased alive on 12-1, 1950, and that death occurred at 1035 A.M., from the causes and on the date stated above.							
23a. SIGNATURE <u>William S. Smith, M.D.</u>		(Degree or title) M.D.		23b. ADDRESS 3251 1/2 1st St		23c. DATE SIGNED 12-16-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12/19/50		24c. NAME OF CEMETERY OR CREMATORY Kessels Private		24d. LOCATION (City, town, or county) (State) P. M. D. Mo	
DATE REC'D BY LOCAL REG DEC 18 1950		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Schneider</u>		ADDRESS Gallatin Mo	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

82207

SEP 6 1953

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed J. Allen Davis Jr
Licensed Embalmer No. 4053

P. O. Address St Louis 10 Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.